

## Medical Control Guideline: VITAL SIGNS

### PRINCIPLE:

1. Vital signs are a key component of the patient assessment utilized in determining the patient's physiological status, and the treatment options that best meet their needs.

### GUIDELINES:

1. Normal Vital Signs
  - a. Adult
    - i. SBP 90-139 mmHg
    - ii. DBP <90 mmHg
    - iii. HR 60-100 bpm
    - iv. RR 12-20 bpm
    - v. O<sub>2</sub> sat ≥ 94% (if patient on home O<sub>2</sub>, measured on O<sub>2</sub> at usual flow rate)
  - b. Pediatric as per [MCG 1309](#)
  - c. Circumstances should also be considered when assessing for and determining cause for concern regarding abnormal vital signs
2. Obtain and document the following vital signs on all patients:
  - a. Blood pressure (for patients < 3 years, document capillary refill instead)
  - b. Pulse
  - c. Respiratory rate and tidal volume
    - Adults – count respirations for 15 seconds and multiply by 4
    - Pediatrics – count respirations for 30 seconds and multiply by 2
  - d. Oxygen saturation
  - e. Level of consciousness
  - f. Pain level using appropriate pain scale
  - g. End-tidal CO<sub>2</sub> level for any patient receiving positive pressure ventilation
  - h. Skin signs
3. Document additional vital signs if measured:
  - a. Temperature
  - b. Carbon monoxide level
4. Repeat and document vital signs:
  - a. On any patient whose initial vital signs were not within normal limits
  - b. When patient's clinical condition changes
  - c. After any treatment
  - d. After administration of medications
  - e. Upon transfer of care
5. The paramedic should report the initial vital signs, the most recent vital signs if different, and any intervening treatments to the Base Hospital and to the Receiving Hospital personnel critical information that is needed for the receiving hospital to prepare for the patient.